UPMC MyHealth

Take a Healthy Step
Proof of Service Submission Form

Use this form to provide documentation of completion of qualifying healthy activities for Take a Healthy Step incentive rewards. Incentives that can be processed using this form include:

- Dental exams
- Vision exams
- Annual physical exam
- Other

Please complete this form in its entirety. Incomplete forms will be returned to the submitter. This is not a reimbursement form.

Company Name (for primary insured): _____

Mail or fax this completed form and documentation to:
Take a Healthy Step Processing
UPMC WorkPartners
600 Grant Street, 7th Floor
Pittsburgh, PA 15219

Fax: 412-454-2942
Please allow two weeks for processing.

A. Subscriber Information

This section refers to the policyholder.

First Name: _____ Last Name: _____

Member ID #: _____ Contact Phone: _____

Email Address: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

B. Activity Details

Instructions:

1. Select Activity Type: one type per block, maximum of three activities on each copy of this form.
2. Enter date the service was received. Service date must be during TAHS coverage and submitted within one year of service.
3. Name and UPMC Health Plan member ID # for member who received service (ID number is listed on the individual's member ID card).

1. Activity Type		2. Service Date/Provider		3. Member Information	
1	Dental exam Vision exam Annual physical exam Other (specify): _____	Date:		Name:	
		Provider Signature:		UPMC Health Plan Member ID:	
2	Dental exam Vision exam Annual physical exam Other (specify): _____	Date:		Name:	
		Provider Signature:		UPMC Health Plan Member ID:	
3	Dental exam Vision exam Annual physical exam Other (specify): _____	Date:		Name:	
		Provider Signature:		UPMC Health Plan Member ID:	

C. Participation

I, Dr. _____ (please print), submit this documentation as proof that _____ (print participant name) completed the examination below.

☐ Annual/Preventive Exam ☐ Dental Exam ☐ Vision Exam ☐ Other (specify) _____

D. Authorization

By signing below, I am attesting that the information documented on this form is accurate to the best of my knowledge. I understand that submission of this form is not a guarantee of incentive reward. All incentives will be processed at the time of receipt and according to rules and account balances at the time of processing.

Printed Member Name _____ Member Signature _____ Date _____

Questions? We can help. Call a Health Care Concierge at the number on the back of your member ID card.

TAHS FRM 15WP1103 (JMS)